MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPLICATION FOR MEDICARE SAVINGS FOR QUALIFIED BENEFICIARIES OR SPECIFIED LOW-INCOME BENEFICIARIES

FOR OFFICE USE ONLY	
DATE RECEIVED	
DCN #1	DCN #2

NOTE: This is **NOT** an application for Medical or Food Stamp assistance. *If you want to apply for these programs, go to http://dss.mo.gov/ and select How do I Find Medical Care or Access Food Stamps; call the FSD Information Center toll free at 1-855-FSD-INFO (1-855-373-4636); or contact a Family Support Division office to request an application*.

☐ I/WE hereby apply for payment of Medicare premiums.

INSTRUCTIONS: Read the application carefully; answer each question completely and accurately. Attach additional pages if needed. If you are unable to complete this application, you may have a friend, relative or someone else help you. Sign, date and mail or deliver the application to the Family Support Division . You may contact the FSD Information Center toll free at 1-855-FSD-INFO (1-855-373-4636) for the address to send the form.

APPLICANT NAME (FIRST, MIDDLE, LAST)

ADDRESS (HOUSE NO., STREET OR RURAL ROUTE, P. O. BOX)	CITY, STATE, ZIP CODE

HOME PHONE NUMBER	WORK PHONE NUMBER	MESSAGE PHONE NUMBER

COMPLETE THE FOLLOWING INFORMATION FOR YOU AND YOUR SPOUSE (IF MARRIED)

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	HISPANIC Y/N	RACE*/ SEX	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	DO YOU HAVE MEDICARE? Y/N

*1. WHITE/ CAUCASIAN 2. BLACK/AFRICAN AMERICAN 3. NO LONGER USED 4. AMERICAN INDIAN/ALASKA NATIVE 5. ASIAN 6. NATIVE HAWAIIAN/PACIFIC ISLANDER

Are all of the persons applying U. S. citizens? ☐ YES ☐ NO If no, list the following information for applicants listed above who are not U. S. citizens: Name, immigration status, registration number, and date of entry:

_____

I/We are residents of Missouri and intend to remain. ☐ YES ☐ NO

Are you applying for Medicare Savings for your spouse, too? ☐ YES ☐ NO

I/We have other health insurance. ☐ YES ☐ NO If yes, complete the following:

PERSON INSURED	INSURANCE COMPANY	POLICY NUMBER	TYPE OF COVERAGE

Are you now employed? ☐ Yes ☐ No If yes, name of employer: _____
Amount you are paid before deductions $ _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice monthly ☐ Monthly

Is your spouse employed? ☐ Yes ☐ No If yes, name of employer: _____
Amount they are paid before deductions $ _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice Monthly ☐ Monthly

Does anyone in your home operate their own business or are they otherwise self-employed ☐ YES ☐ NO
If yes, list who, describe what type of self-employment (babysitting, farm income, other) and amount earned:

_____.

I/We receive other income from the following. Check (✓) all that apply.

	RECEIVED BY	CLAIM NUMBER	AMOUNT PER MONTH
☐ Social Security			
☐ Supplemental Security Income			
☐ Trust Funds/Annuities			
☐ Pensions/Retirement/Disability			
☐ Interest or Dividends			
☐ Veteran's Benefits			
☐ Unemployment Compensation			
☐ Assistance from friends or relatives			
☐ Other (explain where the money comes from and the amount)			

List all cash and securities owned by you or your spouse. Include all checking accounts, savings accounts, certificates of deposit, annuities, cash on hand, stocks, bonds or other investments, notes or mortgages owed to you, property held in safe deposit boxes or any other resources.

CASH AND SECURITIES	IN WHOSE NAME	ACCOUNT NUMBER	LOCATION	VALUE
☐ Other (explain)				

List all personal property owned by you or your spouse. Include Burial lots, Business or Farm equipment, Jewelry (other than wedding and engagement rings, watches or costume jewelry), Property claims in Probate court or other assets.

PERSONAL PROPERTY	LOCATION	VALUE	DEBT
☐ Other (explain)			

VEHICLES – List cars, trucks, vans, motorcycles, recreational vehicles, and others owned by you or your spouse.

MAKE/MODEL	YEAR	OWNER	VALUE	DEBT	HOW IS IT USED?

I/We own or are buying real estate. ☐ YES ☐ NO If yes, complete the following:

LIST KIND AND LOCATION	WHOSE NAME IS ON THE DEED?	CURRENT VALUE	AMOUNT OWED	HOW IS IT USED? (HOME, RENTAL, ACREAGE, OTHER)

I/We have life insurance and/or burial plans. ☐ YES ☐ NO If yes, complete the following:

PERSON INSURED	POLICY OWNER	CHECK (✓) KIND LIFE	CHECK (✓) KIND BURIAL	INSURANCE COMPANY	POLICY NUMBER	FACE VALUE	CASH VALUE

PLEASE READ CAREFULLY AND SIGN BELOW

I/We UNDERSTAND that I/we are entitled to fair and equal treatment regardless of age, sex, race, color, handicap, religion, creed, national origin or political belief.

I/We UNDERSTAND if I/we disagree with the decision concerning our eligibility, I/we may request a fair hearing by contacting the local Family Support office. This request must be received within 90 days of the eligibility decision.

I/We UNDERSTAND that I/we must provide Social Security Numbers (SSN) of all persons applying for MO HealthNet. The SSN is used to determine eligibility and verify information (Section 1137 of the Social Security Act).

I/We authorize the Director of Family Support Division or his/her appointee to investigate and verify these circumstances and statements.

I/We UNDERSTAND that I/we must report any changes in circumstances within ten days of when they happen. Call 1-855-373-4636 to report changes.

I/We UNDERSTAND that it is against the law to obtain or attempt to obtain benefits to which I/we are not entitled. Any false claim, statement or concealment of any material fact whatever, in whole or in part, may subject me to criminal and/or civil prosecution.

I/We UNDERSTAND that I/we must provide complete information regarding any health or accident insurance benefit available to any household member and I/we must report within 30 days any accident for which medical care is received.

I/We hereby authorize all providers of medical benefits who render services or merchandise to me/us under MO HealthNet to release all records regarding such services or merchandise to the Department of Social Services and its representatives.

I/We UNDERSTAND that application for and acceptance of MO HealthNet constitutes an assignment of rights to the Department of Social Services, MO HealthNet Division for payment for medical care from a third party.

Provided I/we are found to be eligible for assistance, I/we wish payments by the MO HealthNet Division and/or the Title XVIII medical insurance program to be made directly to physicians and medical suppliers on any future covered unpaid bills for medical and other health services furnished me/us while eligible for MO HealthNet.

My/our signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF SPOUSE	DATE